Vermont Mental Health Performance Indicator Project

DDMHS, Weeks Building, 103 South Main Street, Waterbury, VT 05671-1601 (802-241-2638)

MEMORANDUM

TO: Vermont Mental Health Performance Indicator Project
Advisory Group and Interested Parties

FROM: John Pandiani
Janet Bramley

DATE: August 17, 2001

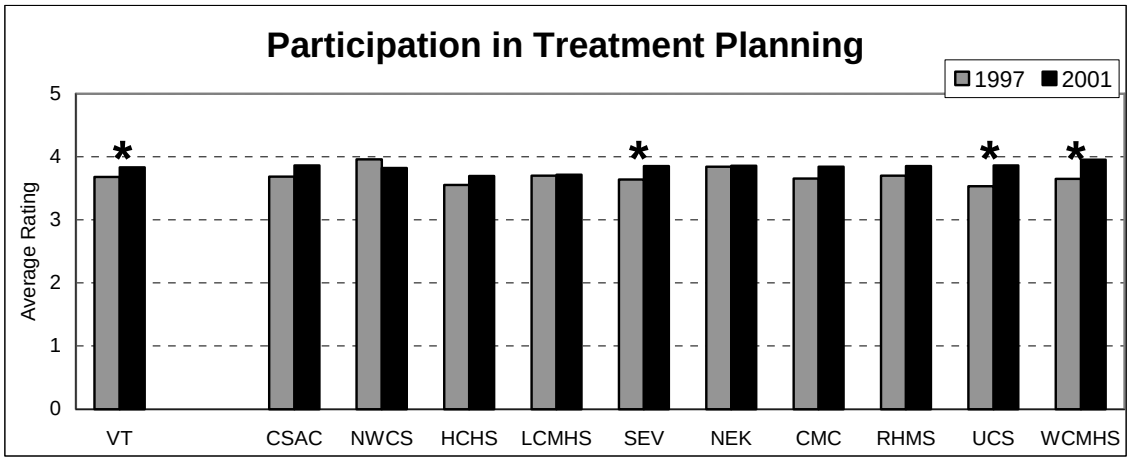
RE: Consumer Participation in Treatment Planning

The attached handout from the 2001 National Conference on Mental Health Statistics provides results of our first round of comparative analysis of the 1997 and 2001 CRT consumer surveys. This analysis was specifically designed to determine if there had been a change in consumer involvement in treatment planning between those two surveys.

As you will see, the analysis demonstrated a statistically significant impact in the desired direction (more involvement in treatment planning for most respondents). Individuals who had been in treatment during both time periods showed the most improvement in treatment planning participation. Individuals who entered or left treatment actually reported less improvement in participation in treatment planning than in their overall evaluation of services. Participation in treatment planning by individuals who enter or leave treatment may deserve special attention from both an organizational and clinical perspective.

Please let us know if you have any questions or would like to see the results of any additional analyses of these data. As always, you can contact us by e-mail at jpandiani@ddmhs.state.vt.us or by voice at 802-241-2638.

Using Consumer Evaluations
To Measure the Impact of a Statewide Training Effort
On Consumer Participation in Treatment Planning



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Presented at the
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20001 An Information Odyssey: Celebrating the Past 50 Years and Promoting the Future
May 29 - June 1, 2001. Marriott Wardman Hotel, Washington, D.C.

This report is in response to advisory group recommendations regarding stakeholder satisfaction (available on line at http://www.state.vt.us/dmh/data/PIPs/pips.htm). The authors wish to thank Karen Vasseur, Lesley Drought, Sheila Pomeroy and Monica Simon and the consumers who took time to evaluate and comment on the Community Rehabilitation and Treatment Programs provided by the Community Mental Health Centers in Vermont.

For More Information Contact: Janet A. Bramley , Ph.D., 802-241-2659, jbramley@ddmhs.state.vt.us

During the Fall of 1997, Vermont's first statewide implementation of the MHSIP Consumer survey found consumer involvement in treatment planning in programs for people with severe and persistent mental illness to be the area of poorest performance statewide (Vermont Department of Developmental and Mental Health, 1998). The questionnaire item "*I, not staff, decide my treatment goals*." had the lowest level of agreement of any item on the questionnaire. Only 66% of the respondents agreed with this statement, compared to a 77% agreement rate for the questionnaire as a whole and 86% agreement for the highest rated item. Participation in treatment planning was among the four lowest rated of the 21 items on the questionnaire at nine of the ten regional community programs, and was the single lowest rated item at half of the programs.

Subsequent to that survey, the Adult Mental Health Division of the state mental health authority developed new statewide guidelines for clinical records that were designed to encourage increased consumer participation in treatment planning. These new guidelines were introduced at a statewide "training of trainers" conference during the fall of 1999, so that each trainer could then institute these practices at their local community mental health center. Since that training, state mental health staff has continued to support consumer involvement in treatment planning whenever they visited local programs.

Beginning in the fall of 2000, Vermont conducted a second statewide survey of people served by community programs for people with severe and persistent mental illness. This survey uses the same instrument and the same data collection methodology that was used in the 1997 survey. This presentation will include both a statewide evaluation of the degree of change in consumer involvement in treatment planning and a comparison of the amount of change at different local programs. A number of interesting methodological issues will be identified and the way in which they were addressed will be discussed. One of the most important issues will be the change in caseload composition over time (some people leaving treatment while others enter treatment) and how this can affect the measurement of change.

Method

The two surveys described in this presentation used an identical version of the MHSIP Consumer Survey. This consists of twenty-two fixed-alternative questions and four open-ended items. The first survey was conducted two years prior to the statewide effort to increase consumer participation; the second survey was conducted one year after the statewide effort. This presentation will focus on consumers' responses to the specific issue of participation in treatment planning.

The Vermont consumer survey was designed with two goals in mind. First, the project was designed to provide an assessment of program performance that would allow a variety of stakeholders to compare the performance of community support programs (CSPs) in Vermont. Second, the project was designed to give consumers a voice and to provide a situation in which that voice would be heard. These goals led to a selection of research procedures that are notable in two ways.

All qualified individuals, not just a sample, were invited to participate in the evaluation. This approach assured the statistical power necessary to compare even small programs across the state, and provided all consumers with a voice in the evaluation of their services.

Questionnaires were not anonymous (although all responses were treated as personal/confidential information). An obvious code on each questionnaire allowed the research team to link survey responses to other data about the respondents (e.g. age, gender, diagnosis, type and amount of service). This information allowed the research team to identify non-response bias or bias due to any differences in the caseload of different programs and to apply analytical techniques that control the effect of such a bias. The ability to connect survey responses to personally identifying information also allowed Mental Health Division staff to contact respondents should strong complaints be made or potentially serious problems were indicated. In such cases, respondents were asked if they wanted their complaints pursued.

For the 1997 survey (Time 1), questionnaires were mailed to all 2357 individuals who had received Medicaid reimbursed services from CSPs in Vermont during January through June of 1997. For the 2001 survey (Time 2), questionnaires were mailed to all 2985 individuals who had received services, regardless of funding source, from CSPs in Vermont during January through June of 2000. In both cases, consumers who had not responded to the first mailing were sent a follow-up after approximately three weeks. The adjusted response rate for Time 1, excluding undeliverable questionnaires and deceased persons, was 53% statewide. At the time of reporting (some questionnaires are still being returned) the equivalent response rate for Time 2 is 47%.

In order to compare consumer's perceptions of their involvement in treatment planning before and after the statewide staff training, the analyses presented here focus on responses to the specific question 18 "*I, not staff, decide my treatment goals" and* on an overall mean score for all item responses at Time 1 and Time 2. Differences between Time 1 and Time 2 ratings for the individual question and overall were analyzed at the statewide and individual program level, using standard independent samples and paired samples t-tests.

T-tests were run for all possible respondent groups: all Time 1 versus all Time 2, a paired group who responded to both surveys, those who received both surveys but responded only once, and finally, those who had only received one survey. Effect sizes were calculated by dividing the difference between Time 1 and Time 2 means for each of these groupings by the Time 1 standard deviation. The impact of the intervention on consumer evaluation was assessed by deducting the effect of secular trend from Time 1 to Time 2 from the single item effect size (Hedges & Olkin, 1985). Given the relatively high response rates, measures of statistical significance incorporated a finite population correction factor (Cochran, 1968).

Results

There was a small increase between 1997 and 2000 in consumers' rating of their participation in treatment planning. In 1997, respondents rated their participation at 3.68 on a scale of 1-5. In 2000, respondents rated their participation at 3.83 on a scale of 1-5. While the effect size for this difference was small (.14), the difference was statistically significant (p=.001). There was also a small and statistically significant increase in overall rating of the community mental health programs, from 3.95 to 4.05. The effect size for this change was .11 (p=.007).

If the change in ratings of participation was not different from the change in ratings of the community programs overall, it would be difficult to attribute the change to the intervention. There was no significant difference between the change in responses regarding participation and the change in overall rating of program performance. The effect size due to the intervention was .03 (.14 minus .11).

Respondents to the surveys represented a mix of new and old clients. Some responded to both surveys, some responded to only one. A paired t-test was applied to the scores of people who had responded to both surveys. A comparison between Time 1 and Time 2 responses revealed a small non-significant increase in ratings of participation in treatment planning from 3.77 to 3.85. The effect size was .07. The effect size for overall ratings was -.02
and the change in overall ratings from 4.04 to 4.03 was not statistically significant.(p.>.05) The effect size of the intervention was .09 (.07 minus -.02) and was statistically significant (p.<.05).

Since the initial difference found in ratings between Time1 and Time 2 could not be attributed to those who had responded to both surveys, the responses of one-time respondents (the 'unpaired' group) were analyzed. This unpaired group consisted of two further subgroups:
those who had been in services and received surveys at both times and those who had been in services at only one time and could, therefore respond only once.

Among those who had the opportunity to respond twice but only responded to one survey, there was an increase between 1997 and 2000 in consumers' rating of their participation in treatment planning from 3.57 to 3.85. The effect size was .24 and the difference was statistically significant (p.=.008). There was a non-significant increase in overall rating of the community

mental health programs, from 3.93 to 4.02, and the effect size for this change was only .10. The effect size for the intervention was .14 (.24 minus .10) and statistically significant (p.<.05).

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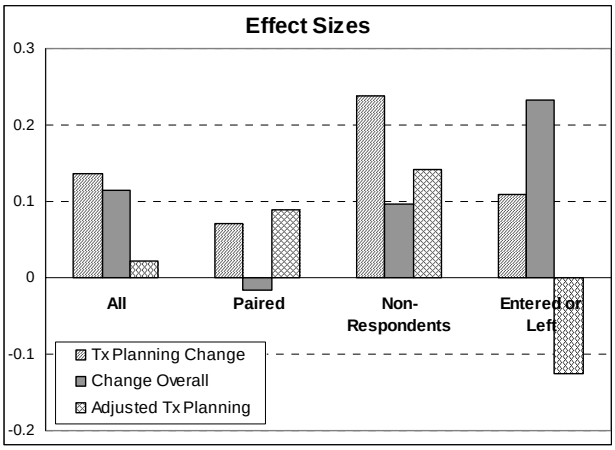

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The final group examined were those who had only one opportunity to respond. A comparison between those who responded at Time 1 to those who responded at Time 2 showed a reverse effect to the other comparisons. There was a small increase between 1997 and 2000 in consumers' rating of their participation in treatment planning from 3.69 to 3.82. The effect size was .11 but the difference was not significant. Within this group, however, there was a statistically significant increase in overall rating of the community mental health programs, from 3.85 to 4.07. The effect size for this change was .23 and the difference was statistically significant (p.=.003). The effect size for the intervention was -.12 (.11 minus .23) and not significant.

Discussion

This analysis has focused on the impact of a statewide training effort that was designed to increase consumer participation in treatment planning in a statewide system of care for adults with severe and persistent mental illness. The results indicate that individuals who had experienced treatment planning before and after the intervention showed the greatest demonstrable effect of the intervention. The individuals who entered or left treatment actually reported less improvement in participation in treatment planning than in their overall evaluation of services. This last group may deserve special attention from both an organizational and clinical perspective.

The analysis demonstrated a significant impact in the desired direction for most respondents. At least two follow-up questions flow naturally from this analysis. First, is increased involvement in treatment planning related to the type and/or amount of service that is provided to consumers? Linking of the survey responses with data on services received before and after treatment for the groups identified in this analysis can provide a valuable test of any hypothesized relationship in this area. Second, is involvement in treatment planning (or general satisfaction with services) related to the outcome of care? Earlier analysis of the results of the first survey reported here found that people who rated their programs more favorably were less likely to be incarcerated during the year after the survey (Pandiani, Banks and Schacht, in press). The combination of the two surveys will allow for more detailed analysis of the relationship between consumer satisfaction and treatment outcomes.

John Russell
40 Main Street
Newtown, VT 05000

October 16, 2000

Dear John,

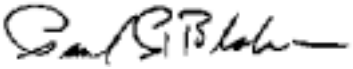
I am writing to you to help us evaluate community mental health services in Vermont. Your opinions and your responses are of great value to us. Your participation in this survey is voluntary, and your answers will have no effect on your health care coverage. Your clinic will not know that you are participating in the survey.

Your responses to this survey will not be available to anyone other than our research staff. Results will only be reported in aggregate form, and will not identify specific individuals. The code on the questionnaire will allow us to link your responses to information about your insurance coverage, and to assure that you do not receive another questionnaire after you answer this one.

We hope your response will help to improve the quality of health care received by Vermonters. If you would like to receive a summary of the results of this survey, please indicate so on the last page of the questionnaire. If you have any questions, please feel free to call Doug Clifton at 802-241-2604.

I thank you in advance for your participation.

Sincerely,



Paul R. Blake, Director
Division of Mental Health

PRB/ld
Enclosure

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